Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CHIROPRACTIC CARE

Controls Used by Medicare, Medicaid, and Other Payers

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E X E C U T I V E S U M M A R Y

PURPOSE

To describe how Medicare, Medicaid, and private insurers control chiropractic benefits.

BACKGROUND

The Balanced Budget Act of 1997 required the Health Care Financing Administration (HCFA) establish new utilization guidelines for Medicare chiropractic care by January 1, 2000. It also eliminated the X-ray requirement. In addition, New York recently enacted legislation requiring private insurers to include chiropractic coverage in their benefits packages.

We initiated two inspections to better understand the impact of these changes on the Medicare and Medicaid programs and to learn more about utilization controls. This report, "CHIROPRACTIC CARE: Controls Used by Medicare, Medicaid, and Other Payers, (OEI-04-97-00490)" describes Medicare, Medicaid, and private insurers' mechanisms for controlling expenditures and protecting the chiropractic benefit from potential waste and abuse. A companion report, "CHIROPRACTIC CARE: Medicaid Coverage, (OEI-06-97-00480)" describes current and expected chiropractic care benefits under State Medicaid programs.

Medicare, Medicaid, and private insurers do not consider control of chiropractic benefits a high priority or an area of major concern. All commented that more could be done to control utilization of the benefit but that resources are better spent controlling other more costly benefits.

FINDINGS

We found that Medicare, Medicaid, and private insurers rely on utilization caps, X-rays, physician referrals, co-payments, and post and prepayment reviews, in varying degrees, to control utilization of chiropractic benefits. Utilization caps are the most widely used, but these and other controls did not detect or prevent unauthorized Medicare maintenance treatments.

Utilization Caps Are the Most Widely Used Control Mechanisms

Ninety-five percent of Medicare and 46 percent of Medicaid programs use soft caps that can be exceeded with appropriate justification. Hard caps, which cannot be exceeded, are used by 50 percent of Medicaid programs and 94 percent of private insurers. Federal costs for Medicaid chiropractic benefits can exceed those for Medicare because Medicaid utilization caps are typically higher than those for Medicare.

X-rays Provide Little Control of Chiropractic Benefits

Few private insurers or Medicaid agencies require X-rays to document treatment necessity. Medicare currently requires X-rays; however, elimination of the X-ray requirement should have little impact on chiropractic controls since most contractors do not use X-rays as a control mechanism.

Physician Referral Is Commonly Used as a Control Mechanism for Managed Care, but Not for Fee-For-Service Plans

Sixty-eight percent of Medicaid and 66 percent of private managed care organizations used physician referrals to help control chiropractic utilization. However, only 8 percent of Medicaid and 9 percent of private fee-for-service plans required physician referrals. None of the Medicare fee-for-service plans required physician referrals.

Co-payments, Coinsurance, and Deductibles are Used to Help Control Chiropractic Benefits by Medicare and Private Insurers, but Not by Medicaid

Private insurers' co-payments ranged from $5 to $15 while Medicare coinsurance equaled 20 percent of approved charges. Both private insurers and Medicare used annual deductibles. Private insurers' deductibles ranged from $200 to $500 and Medicare's deductible equaled $100.

Prepayment Reviews Do Not Control Chiropractic Benefits

Medicare and Medicaid contractors typically do prepayment reviews, however, it is basically a forms verification process. For those claims that exceed the soft caps, Medicare and Medicaid medical necessity prepayment reviews are mostly paper audits.

Post Payment Reviews are Used by Medicaid, but Not by Medicare, to Help Control Chiropractic Benefits

Sixty-five percent of Medicaid contractors use post payment reviews to help control chiropractic utilization. Medicare contractors, however, rarely conduct post payment reviews of chiropractic claims.

Unauthorized Chiropractic Maintenance Treatments are Not Detected and Prevented

HCFA policies preclude Medicare reimbursements for chiropractic maintenance treatments. However, only 40 percent of Medicare respondents claimed to do utilization reviews to identify and prevent such treatments. Our analysis identified over $68 million in probable chiropractic maintenance treatments in 1996. If left unchecked, this could result in as much as $447 million in improper Medicare payments from 1998 through 2002.

RECOMMENDATIONS

This report describes controls used by Medicare, Medicaid, and other payers for chiropractic benefits. Utilization caps were the most widely used control mechanism. Needless to say, their intent is to limit the quantity of services. However, neither the utilization caps, nor any of the other controls, detected and prevented reimbursements for unauthorized Medicare chiropractic maintenance treatments.

Accordingly, we recommend that HCFA develop system edits to detect and prevent unauthorized payments for chiropractic maintenance treatments. HCFA may do so by:

- requiring chiropractic physicians to use modifiers to distinguish the categories of the spinal joint problems (i.e. acute, exacerbation, recurrence, and chronic), and

- requiring all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy.

COMMENTS

The HCFA Administrator, the Assistant Secretary for Planning and Evaluation (ASPE), and the Assistant Secretary for Management and Budget (ASMB) commented on our report. The full text of their comments are in appendix C.

The HCFA concurred with our recommendations. The Balanced Budget Act of 1997 required HCFA to develop utilization guidelines for chiropractic care. In developing such guidelines, HCFA will develop modifiers to distinguish categories of spinal joint problems, and utilization frequency edits as we recommended.

ASPE agreed that edits to identify inappropriate billings seemed desirable. However, ASPE commented that our use of "averages," on pages four through six, to summarize the range of utilization caps was inappropriate because they did not reflect "real practice." Our report provides the reader both the average utilization caps and the actual utilization caps for all Medicare and Medicaid respondents.

Further, ASPE suggested that more information is needed to substantiate two State Medicaid Administrators' claims that physician referrals are effective controls for chiropractic services. Specifically, ASPE wanted to know how these States measured effectiveness. Additionally, ASPE noted that it would be helpful to know how the use of chiropractic services is distributed between managed care and fee-for-service providers. These questions were not part of the scope of this study. However, we plan to continue our analysis of chiropractic services and utilization in the future. These and other questions are likely topics for inclusion in future analysis.

ASMB expressed serious concerns about the methodology we used to estimate payments for probable inappropriate chiropractic maintenance treatments. Specifically, ASMB was concerned about our use of a 10 percent estimate to represent the Medicare population who received

chiropractic care for chronic conditions. The 10 percent estimate, furnished by the American Chiropractic Association, is a universal percentage estimate of the population at large. Demographic data and specific analysis is not available to differentiate between the Medicare population and the population at large. However, we contacted several Medicare Carrier Medical Directors who stated, based on their reviews of Medicare chiropractic claims, that the 10 percent appeared to be a reasonable estimate for the Medicare population.